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CLINICAL NOTES ON A RECENT SERIES OF SURGICAL CASES.

BY THOMAS H. MANLEY, M. D.,
NEW YORK.

(Continued from Last Number.)

HERNIA—VARIOUS TYPES.

Sixteen cases of various types of hernia have come under my notice since the beginning of the present term; these included strangulated, incarcerated, reducible and irreducible cases. But one case required operation for strangulation. The operation was performed late at night by a member of the house staff.

Deaths in Strangulation Attributable to Delay and Avoidable Errors in Operating—This case which terminated mortally was most fruitful in suggestion and in pointing the way to avoiding mistakes in treatment. The case was neglected in the beginning by the practitioner who was first called persisting in violent taxis and allowing his patient to suffer until collapse set in, before sending for or calling in active surgical relief.

The next oversight was committed in the details of operation. A knuckle of intestine partly twisted on itself, with a patch of gangrene about the size of a quarter extended through the glandular and muscular tunics, occupied the walls of the bowels, though there was no perforation, as the outer fibro-cellular coat was intact. Vomiting ceased after the constriction was relieved and the intestine returned; but the man did not react and sank thirty hours after operation. On autopsy it was found that a fatal error had been committed

in the management of the extended coil. The adhesion which held the coiled, bent surfaces of the intestine together had not been liberated and, in consequence its lumen remaining completely obstructed, internal strangulation followed, thus removing every possible hope of recovery. The gangrenous area in my opinion was not enough to seriously call for resection, the use of the Murphy anastomotic button or other adjustment, inasmuch as it extended only about half way over the entire cylinder and would undoubtedly have taken care of itself by taking on adhesion to some of the neighboring viscera, thereby preventing any possible leakage.

Critical Inspection of the Protruding Mass and Thorough Liberation of all Constriction, both within the Sac, the Canal and at the Internal Ring. Indispensable in all Cases of Operation for Strangulation—In all cases of operation for strangulation after we have freely divided the points of stenotic impediment, it is of the greatest importance that we critically inspect the conditions of the ectopic viscera and completely liberate the imprisoned structures. A failure to do this renders an otherwise life-saving operation inert in its effects. A practical demonstration of this came under my notice recently. A man was seized with symptoms of strangulation after stool. He had a chronic incarcerated inguinal epiplocele. An incision was made down on to the upper surface of the mass, the omentum exposed and the inner ring divided. But there was no relief of the symptoms after operation and the patient sank unrelieved the following day. On autopsy a loop of intestine was found caught,

crushed under and concealed by the omentum. This had entirely escaped detection and continued occluded after the epiplocele was exposed.

Treatment of Reducible Hernia— Nine cases of reducible inguinal hernia have been examined by me within the past ten weeks. My practice in this class of cases is not to advise operation unless the hernia is progressively enlarging, is painful, threatens strangulation, is not trussable or the patient is desirous of relief from the deformity. Besides the class enumerated it is my custom to recommend a radical cure in females or in those individuals whose deformity constitutes an impediment to entrance into the civil or military service. But one of these nine which came to me was regarded as appropriate for radical cure.

He was a young man who had hernia since childhood. It was of the indirect inguinal type. This was operated on with gratifying results, the patient leaving the hospital in two weeks.

O'Hara's or the Australian Operation the Best for Open Treatment— Of the almost infinite number of operations recommended during the past ten years for cure of hernia there is none which in so large a measure fulfills the requirements with so little mutilation as the operation devised by Mr. Henry M. O'Hara, of Melbourne, Australia. Briefly described it consists in an isolation of the neck of the sac, its division and retraction up through the canal and internal ring, to the fascia transversalis, where it is anchored by absorbable, suture material. It entails no weakening of the abdominal walls by divisions of large vessels; there is no drainage required and no disfiguring scars left. In fifteen cases so treated by me since April, 1894, there have been no relapses.

ABDOMINAL SURGERY.

Without doubt in the whole field of medical science and since its earliest dawn there has never been anything to equal the stupendous progress made in abdominal and pelvic surgery during the past twenty years, and in this, let medical history

record it, America has occupied the position of the pioneer. In 1881 the celebrated Sims gave to the professional world his conceptions on the possibilities of surgery in this direction; though unhappily he did not survive to realize the fruition of his hopes. Biglow had perfected lithotrity, at the International Medical Congress, in Washington, in 1886. Nicholas Senn presented his thesis on the surgery of the intestine and startled the rank and file of the profession by the immensity of his original and marvelous researches and experimentation on abdominal surgery in the lower animal, and his lucid demonstration of their application to man. Abbe had been a generous contributor in this line and posterity is indebted to Sands for opening the way to operations on the appendix, since perfected by McBurney, and through which thousands of lives have been saved. It has rendered necessary the rewriting of the pathology of the peritoneum. As would seem the climax of all, the young Chicago surgeon, Murphy, has invented an anastomotic button, the very acme of human ingenuity, which has rendered the surgery of the intestine more expedient and safer than ever.

APPENDICITIS.

Timeliness and Skill in Operation on the Appendix— During one week from April 5 to 13, in this year, seven cases of severe abdominal disease came under my notice. Six were of appendicitis, four were of the perforating type. Two came into the hospital in the advanced stages, too late for relief by operation and both died within twenty-four hours after entrance. Two were operated on, with perforation of the appendix in both cases. In one there was a double perforation with general peritonitis. Both recovered. Two mild cases of the recurrent type were treated by palliative measures, recovered. In one abdominal case which was brought into the hospital great prostration was present. My colleague, Dr. A. Palmer Dudley, was of the opinion that there was mechanical obstruction, though it was my impression that it was the appen-

dix which was at fault, and that obstruction was due to intestinal paresis. The abdomen was so extremely tympanitic that it was impossible to definitely locate the structures. On section the appendix was found healthy, and, as Dr. Dudley had predicted, the small intestine was found obstructed by a band at about its centre. The patient rapidly sank under ether before the incision could be closed.

It was formerly my conviction that as the danger in operating itself seemed to me very great, and the larger part of those cases of appendicitis do well under medical treatment alone, surgical interference was not proper in any except rare instances. Later experience has convinced me that this position is not logical, and that in all cases of appendicitis which show a tendency to persistently recur or are of the acute fulminant type, the correct course is prompt operation. The results in operation depend almost entirely on operating at just the right time and performing the operation with skill and celerity. The time to operate is, and always probably will be, very difficult to determine.

Its performance for a successful issue in a large number requires special skill and experience. A small incision, the quick ferreting out of the appendix under the trained finger, the neat and aseptic amputation of it, without the loss of unnecessary time, or trauma of the peritoneal count vastly in the patient's favor.

On the 28th of April Dr. J. A. Hoffheimer called me in consultation to see a case of appendicitis under his charge with the view of determining the propriety of an operation.

The patient was a boy of twelve, who had had previous attacks. It was the sixth day of his illness when I saw the case. At this time his pulse was 143 per minute, the temperature 103 degrees; there was some vomiting and severe pain, when morphine was not pressed. The abdomen was extremely tympanitic, and over the appendix sensation to pain on pressure was extremely acute, and all the abdominal areas were hyperesthetic.

After a careful examination of the case, giving due weight to the various serious symptoms present, the lad's grave condition, and the uncertainty of results after radical measures, when the advanced stage of the disease is reached, my opinion was that nothing definite could be promised by operation, and that it was possible that recovery might ensue by energetic constitutional measures. Three days later the boy died just at a time it seemed that peritoneal inflammation had subsided. Now my regret is that I did not operate. Indeed, there can be scarcely a question that in all these cases, no matter what the stages of inflammation may be, when we are once assured that the appendix is the actual seat of serious disease an immediate operation should be invariably insisted on.

JOINT DISEASES.

The Influence of Systemic Cachexia on the Arthropathies which Succeed Injuries—Several cases illustrating the various phases of joint injuries and diseases have lately come into the hospital for treatment. The dominating pathological changes attending these were rheumatism and tuberculosis. There can be scarcely a doubt but various constitutional disturbances impress their stamp on many traumatisms and enhance the vulnerability of various organs and structures. This is especially true of the tissues which enter into the joints.

The articular heads of the bones are the centre of great activity during the processes of growth and development. As a move in the direction of arriving at an accurate knowledge of the precise pathological conditions which obtain in certain arthritic elements it would be well if the term "hip-joint disease" or "knee-joint disease" were abolished.

A young man in late autumn, 1894, sustained a sprain of the knee, in a football game. He was treated at home and elsewhere for "knee-joint disease." Failing to secure relief from the various fixation appliances which had been employed, he entered Harlem Hospital on the 12th of March. On a critical examination of

the joint there was no evidence of any morbid changes in the capsules or cartilages; but the head of his tibia was enlarged and exquisitely sensitive. The cancellous centre of this was opened freely; the trephine entering just under the insertion of the tendon of the sartorius. A pus cavity was tapped and a considerable residue of necrosed bone curetted out. All pain immediately ceased, the spasmodic contractions of the hamstrings passed off. He returned within four weeks to his trade of a painter when his "knee-joint disease" (?) was cured. A young man entered later, who a few days before had violently wrenched his knee. He was sent in to have the supposed hemorrhagic distension of the capsule relieved by evacuation through an orthrotomy.

It was found to consist entirely of a hematoma into the loose cellular tissue outside the aponeurotic investment of the knee-joint and wholly disappeared by a few days' rest, with moderate bandage-pressure.

A young woman of good physique was sent into the hospital for the treatment of "acute suppurative synovitis of the right knee-joint." On inspection it was found that the patella was displaced inward and deeply lodged under the projecting surface of the voluminous fullness, coming down from above. The case was clearly one of acute phlegmon under the fascia-lata; its fluid contents being arrested from advancing further downward by the insertion of its fibrous hood into the lateral surfaces of the quadriceps tendon. The articulation had wholly escaped. An incision, evacuation and drainage gave immediate relief and final recovery was rapid.

Rheumatic Pain Sometimes Antecedent to Trauma of the Joints—Rheumatic affections of the joints of the lower extremities are sometimes preceded by a weakening of the muscles. This precedes the intense pain and swelling. The person about to be seized is conscious of a sense of lameness or unsteadiness in the articulation. He is now liable to a fall or wrench, when all of a sudden, all the typical symptoms of acute in-

flammation set in and he has a pan-arthritis. To mistake this mixed condition for a joint trauma alone, and concentrate all one's attention on the local trouble may lead to serious results. Protracted fixation of a limb always interferes with its full nutrition and arrests its growth in growing children.

Several cases have been seen by me during the spring months, supposed to be organic disease of the joints, promptly recovered when all retaining supports were removed the joints allowed full liberty and rheumatic remedies pressed.

Resection of Diseased Joints or Conservative Methods—Formal resection of a joint is never done in my service, unless there is evidence that disease has completely disorganized it. In those cases it remains a question if an amputation is not preferable. Resection of a joint, let it be remembered, means its entire destruction. In the child, under ordinary surroundings, after a time tubercular disease of the heads of bone often tends to spontaneous arrest. My own practice in aggravated cases of this type is to open and curette the joint preserving the ligament and cartilages. In adult tuberculosis of bone reaction will not arrest the progress of the malady which is now usually generalized and progressive.

MAMMARY TUMORS.

Among the cases seen and treated by me within the past quarter were five cases of tumor of the mammary gland. Three of them were malignant, of the epithelial variety, one recurrent. Of the other two, one was a dermoid cyst and the other tubercular.

The Therapy of Mammary Neoplasms—The cyst was readily decorticated, the incision promptly healing. Seven years before she had the opposite breast removed for the same condition, in which, up to the present time there had been no recurrence. An incision, grattage and drainage cleared away the strumous infiltrate.

The principles which should govern us in the management of cancer of the breast are still subjudice, indefinite and unsettled, although the

reports coming in from the results of tumor extirpation, of all the axillary absorbents with the complete removal of the mammary gland, point to a great improvement of this method, above all others.

One of three cases was treated by me in this plan for the reason that there was already an immense secondary growth in the axilla. In her case there was a large, hard infiltrating, secondary growth, in the axillary hollow, which required a very delicate dissection to remove it without damage to the main arterial trunk, to the trunk of which the tumor maintained a firm grip.

The long thoracic artery with the thoracic alarix were divided and the axillary vein opened. But all hemorrhage was readily subdued. The patient ultimately made a good recovery, though with marked limitation of shoulder action, in consequence of the cicatricial construction in the apex of the axillary space. The direction of dissemination in scirrhus is always centripetal along the course of the absorbent vessels. The adenomatous structures of the lymphatics serve as outposts to prevent systemic infection, and no doubt are invaded at an early date. The complete operation is one which entails an extensive mutilation of tissue and is perhaps more dangerous to life than simple mammary excision; but the promise which it gives us against relapse more than outweighs these objections.

One patient with a small, hard scirrhus refused operation, and later I was informed, went into the hands of a charlatan.

A case of recurrent cancer had been first operated on by me in November, 1884, and again six months later. She had refused any further cutting operation.

In her case the powerful chemical cauteries have been employed by me with the hope of being able to clear away fungating crop of pulpy granulations, which occupied that site of the scar tissue. It succeeded fairly well at first, but its repetition in an attempt to destroy the substrata of neoplastic elements, was attended by such agonizing pain and

positive shock that life was endangered, and my patient declared she would rather die than undergo the ordeal again.

When arsenical paste was employed, although its activity in charring the tissues was decided, yet there were invariably symptoms of constitutional poisoning; numbness of the extremities from toxic neunitis, nephritic irritation, with sore throat and very severe gastric symptoms, followed in every instance.

My own unsatisfactory experience with caustics has led me to employ them in malignant growths with caution, and never, except on those which occupy the periphery and are of a very limited area. In labial epithelioma or on senile growth, involving the nose or eyelids, the caustic substance will serve a most useful purpose.

The above incomplete notes and comments are on a class of cases that commonly come under our observation, and of late years have been treated with such success as was heretofore quite impossible. If in only a limited degree I have succeeded in calling attention to some of their most salient features and indicative rational methods in their management, my aim has been accomplished.

A PLEA FOR EFFICIENT LEGISLATION REGULATING MEDICAL PRACTICE.

BY PERRY H. MILLARD, M. D., OF ST. PAUL.

(Continued from Last Number.)

Owing to the difficulty in securing indictments and the consequent tardiness of legal processes the penalty for violations of the provisions of this form of legislation should be by penalties imposed by a justice or a municipal judge; the latter method has given satisfaction as far as I am aware. Reasonable efficiency upon the part of the officers of these boards has been awarded by a full compliance with the provisions of this form of statute in all instances. The Governor should have the appointing power, being responsible for the successful operations of the dif-

ferent State boards. Experience satisfies us that the so-called mixed boards are doing satisfactory work and operating in perfect harmony. Seemingly no excuse exists for the duplicate boards operating in a very few States. At present approximately 30 States possess legislation regulating medical practice. Seventeen States have a form of statute that fails to recognize the diploma as evidence of fitness to practice; consequently they may be classed with those States operating under efficient acts. In the latter class of States I particularly desire to call your attention to the results of work thus far accomplished. In a paper read before this learned body, at Detroit, Mich., in 1892 I suggested the future influences of these boards as most important in shaping the future medical education in this country. I submit data at this time confirmatory of the position then taken and reaffirm my former suggestion that future legislation will in a great measure determine and govern the work of the teaching bodies of the country.

I am deeply indebted to the officers of the various boards for courtesies extended and regret that space forbids reference to many suggestions and conclusions arrived at in the work of the different boards.

Data have been obtained from the following named States: Alabama, Minnesota, Maryland, North Dakota, North Carolina, New York, New Jersey, Virginia and Washington.

The subjoined table indicates briefly the work of these boards:

State.	Examined.	Licensed.	Rejected.	Per cent.
Alabama	647	558	89	0.862
Maryland ...	150	105	25	0.806
Minnesota ..	641	499	142	0.778
New York ...	967	797	170	0.824
New Jersey..	447	417	30	0.955
North Carolina	615	508	207	0.71
North Dakota	81	76	5	0.938
Virginia	835	613	222	0.734
Washington ..	207	167	40	0.806
Totals ...	4670	3740	930	0.822

It will be observed that of 4670 persons examined but 82.2-10 per cent. were successful in securing a

license. The 930 unsuccessful applicants have, we doubt not, principally located in States not protected by this form of legislation.

I am pleased to direct your attention to the good work of the Minnesota board. The first act regulating medical practice in this State became operative in March, 1883. It was the form of legislation at present in force in Illinois. It was in operation five years, being supplanted by the present law. The present act requires an examination of all persons commencing the practice of medicine and as amended by the last Legislature the minimum of requirements is changed, demanding that all graduates of later date than 1898 furnish satisfactory evidence of having attended at least four courses of lectures in different years, of not less than six months duration each.

We have in Minnesota a practical illustration of the position taken in my former paper: "That in medical legislation we have the only solution of the problem of higher medical education." Having drafted these bills and by force of circumstances been somewhat conspicuously aggressive in urging their enactment, I have, in consequence, witnessed their operations with some concern and interest. The result is all that the most sanguine could have anticipated. In a period of 12 years the proportion of physicians to the population in Minnesota has been reduced from one practitioner to ever 650 in 1883 to one to every 1000 in 1895. The State has been substantially rid of the traveling charlatan. The present able secretary, Dr. McDavitt, informs me that the medical census just completed is accurate and that the present operation of the law is quite faultless. We therefore conclude that in one State at least the number of physicians has been reduced to a number commensurate with the demands of the people.

The work of the New York board is attracting considerable attention. Notwithstanding pronounced opposition and many embarrassments the act is destined to strengthen the character of the profession in this

State. From advance sheets kindly furnished for use in this paper I observe the following verification of a position taken by the secretary, James Russell Parsons, in his 1893 report. He reiterates that the records of the past year conclusively prove the position taken in his 1893 report, "That the new law proves a barrier to the ingress of the incompetent, has operated to raise the standard of preliminary education, improve the methods of teaching and terms of study of the different schools of medicine."

The following resolution from the president and secretary of the board to the State Medical Society is significant and should meet the approval and support of every member of the profession of this great State, "Resolved, That in the opinion of this Board the best interests of the public and medical profession would be materially advanced by gradually increasing the minimum of requirements as to general preliminary education till no candidate be entitled to matriculate in 1897 at a degree granting medical school in this State that has not completed at least a full high school course."

I am pleased to note that this bill has already passed the Senate in New York and is in a fair way of becoming a law. If it becomes operative it will operate to improve the character of matriculation in other States. Greater co-operation is necessary between different State boards, as it is essential that harmony of policy exist as far as practicable. As in foreign countries their relations to the profession and teaching bodies is most important, their functions being that of professional censors of the conduct of the members of the profession, and guarding at the same time the avenues of entrance to professional work. It being the duties of these boards to protect the people from professional incompetency and charlatanry the duties are briefly comprehended in the performance of the following duties: 1. In establishing a minimum curriculum for all colleges whose alumni apply for a license to practice. 2. The individual examination of all

persons wishing to practice medicine in the commonwealth. 3. A professional censorship, granting the right to refuse or revoke a license for incompetency and gross unprofessional or dishonorable conduct.

As this form of legislation becomes more fully understood and appreciated by the better class of schools it will be observed as one of the most certain and reliable avenues of placing before the profession of the country the character of work being done in all colleges whose alumni apply for a license. A school doing honest work has little to fear at the hands of these boards; upon the contrary, as suggested in my former paper, it will be found that the proportion of applicants able to pass successful examinations will be a certain index of the character of instruction afforded students in the respective schools.

While the proportion of applicants successful is only 82 per cent., it will be found that from the schools heretofore operating under a high grade of requirements that thus far at least in the work of these boards nearly all graduates are successful in obtaining license upon examination. In substantiation of this conclusion I again submit data, using therein the same schools as in my former paper.

The following table indicates the proportion of students successful on examination from alumni of schools heretofore operating under the three years' curricula:

Colleges.	Examined.	Licensed.	Rejected.	Per cent.
Harvard	31	31	0	1.000
Columbia	123	118	5	.952
Univ. of Penna.	126	123	3	.976
Univ. of Michigan ..	83	78	5	.940
Northwestern Univ. ..	26	22	4	.846
Univ. of Minnesota ..	149	148	1	.992
Totals.	538	520	18	.964

I cannot but conclude, gentleman, that efficient medical legislation will operate to bring about the following results, as applied to the profession and public.

1. It will protect the people by affording a profession of greater intelligence.

2. It will suppress charlatanry.

3. It will reduce the number of persons practicing medicine to a number commensurate with the demands of the people.

4. It will reduce the number of medical colleges, at present far above legitimate demands.

5. It will raise the general standard of professional fitness, assuring us a professional prestige in the future, becoming the most important of the learned professions.

In conclusion, we appeal to the profession to renew their efforts in securing efficient medical legislation, believing its operations will result most beneficially to both public and profession.

LOSOPHAN.

EY WILLIAM F. WAUGH, M. D.,
Professor of Medicine, Chicago
Post Graduate Medical College, etc.

So many new remedies are placed before us that there is danger that really valuable ones may be overlooked, in the crowd of competition. This fate seems to threaten losophan; since I find no mention of it either in Becquerel-Limousin's *Nouveaux remedies* or the work upon the local therapeutics issued by Harrison Allen and others.

Losophan is a tri-ido-cresol, resulting from the action of iodine upon m-oxytolnic acid in the presence of an alkali. It is slightly soluble in alcohol, freely in ether, benzol or chloroform. Fixed oils at 60 degrees take it up readily. Losophan occurs in white needles. It contains 80 per cent. of iodine. Its antimycotic powers should, therefore, be considerable; and this has been proved by clinical trials. Among the affections in which it has been used successfully are mycosis tonsurans of the body, herpes tonsurans, sycosis, onychomycosis tonsurans, pityriasis versicolor, eczema, prurigo, acne rosacea, epizoon, pediculosis, scabies, chancre and the wounds from operations upon buboes.

In pityriasis versicolor losophan was applied in solution and ointment of one to two per cent. In eczema it proved irritating, but exerted

a very favorable action upon chronic infiltrations and especially proved efficacious in relieving the itching. In prurigo and in a number of cases of itching from various causes it gave speedy relief. Sycosis has been cured by ointment of one to two per cent. in obstinate cases that had resisted all previous treatment. In acne and rosacea improvement has always followed the application of one to three per cent. ointments, without much irritation. For pediculosis of all varieties the solutions were made of one per cent. with 25 per cent. of vinegar. Scabies required ointments of two to three per cent. A dusting powder of one per cent. has been employed upon cutaneous ulcers, and after operations upon chancre and buboes.

The contra indication for losophan is acute dermatitis, in which it increases the irritation. The formula recommended for the solution is as follows:

Losophan 1.0 dissolved in alcohol, 82.5; adding castor oil, 7.5, and distilled water, 9.0. If a stronger solution be required add losophan and use less water. Ointments of 10 per cent. have been used with good effect in scabies and in sycosis.

My own experience with losophan covers a period of two years. I feel tempted to denominate it the antipruritic, so universally has it proved efficacious in relieving itching of every description. Very severe and obstinate cases of pruritus ani and vulvae, the itching legs of plethora, the pruritus of chronic eczema, have been relieved by losophan. In acute eczema, and whenever there is inflammatory reaction, losophan must not be used in a strength exceeding one per cent., or it may cause irritation. A patient recently came to my clinic with acne and rosacea of several years' duration, defying all previous treatment. She was given a one per cent. lotion of losophan, to be used twice daily. In one week she returned, the acne nearly well, but several spots of rosacea somewhat irritated. A little ointment was applied to these and the lotion continued, recovery was complete in two weeks more. There is one very annoying

affection for which I have tried many remedies unsuccessfully, until losophan proved effective. This is pruritus of the prepuce. The mucous membrane has a puffed, reddened, velvety appearance, and can be felt to be thickened. The itching is intense, and is aggravated by rubbing. In one case the pruritus occurred every time the patient had connection with his wife; in another the affection appeared only after browsing in strange pastures; while in a third it would begin if the organ were not washed in cold water without soap at least twice a day. There was no secretion in either of the cases observed by me, though one was accompanied by eczema of the anus. In all the application of losophan one per cent. in petroleum gave speedy relief. I have restricted my remarks to those cases in which losophan has given better results than any remedies previously employed. The field of its utility is by no means limited to the cases quoted; but when the results are not better than those obtained from remedies in common use it is better to omit such data as uselessly adding to the bulk of medical literature.

MY EXPERIENCE WITH THE IMMEDIATE REPAIR OF UTERINE INJURY FOLLOWING LABOR.

By A. PALMER DUDLEY, M. D.

In the February (1895) issue of the American Journal of Obstetrics, Dr. Dudley states that he has performed immediate repair on 21 cases since 1889, and has yet to see the first bad results from such manipulation and repair of the uterus. He makes it his rule, while waiting for the placenta to be delivered (during which time he allows the patient to sleep under the influence of a few drops of chloroform), to examine the cervix, perineum, urethra, vestibule, etc., and if he finds a tear of the cervix, he entrusts the chloroform to an assistant, delivers the placenta, and, after thorough disinfection and aseptic precautions, repairs the rent with the patient in Sim's position and by the

aid of a large Sim's speculum. He prefers No. 5 catgut for the sutures.

A series of five cases are reported to illustrate his methods and success, and he summarizes as follows:

1. Suturing of the lacerated cervix properly immediately after delivery will result in primary union of the same and prevent many of the evils that follow in the wake of a union by second intention.
2. The fear of septicemia attending the manipulation of the cervix for the same, and the introduction of poisons which will induce septicemia at the same time, is an unfounded one, and would be dissipated by giving such work a proper test.
3. It is a method of procedure more justifiable than an immediate repair of the perineum, which the profession of today universally advocates.
4. The securing of primary restoration of the laceration hastens involution, prevents subinvolution and the various forms of displacement which are induced by it in such an overweighted organ.
5. That catgut is the proper suture and perfectly safe and reliable when properly prepared.

Prescriptions.

Vomiting in Pregnancy.—Paint os with cocaine, or give by mouth, combined with antipyrin:

B—Chlorhyd. cocaine 1½ gr.
Antipyrin 16 gr.
Aq. dest. 4 oz.

Sig.—Teaspoonful every half hour until the vomiting ceases.—Lutaud.

Dry Tongue in diabetics, etc.:

R—Pilocarpin. nitrat. 1-3 gr.
Spirit. vini dilut. 20 minims
Aquæ 1 dram

M. Sig.—The tongue is to be moistened with five or six drops of this solution four or five times daily.

Gonorrheal Cystitis:

R—Pyoktanin 15 gr.
Boiled distilled water. 2 scruples

M. Sig.—Inject morning and evening for ten to fifteen days.—Lutaud.

Rachitis:

R—Phosphorus 0.01
Cod-liver oil 100.
Saccharin 5.

Essence of lemon. 2 gr.

Teaspoonful daily.—Guinon.

Eczema of the Vagina:

R—Ichthyl ammon. 1½ to 2 parts

Amyli triticin,

Zinc. flor. aa 12 parts

Vaseline 25 parts

M. et fit pasta.—Von Sehlen.

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PHILADELPHIA, JULY 13, 1895.

THE MEANING OF PERCENTAGE AS APPLIED TO ANTISEPTIC SURGICAL DRESSINGS.

Within a few weeks past there have appeared in the pharmaceutical journals a number of articles in discussion of the question which forms the caption of this paper. The question is a very simple one and may be briefly stated, and it would seem at first thought that there was no occasion for any great amount of agitation of it. But because of the existence in the market of surgical dressings of two kinds, dry and moist, prepared in accordance with different theories or principles, and severally exploited by various houses, each active in advancing arguments in support of its own position, a little investigation shows considerable confusion relative to the matter. The question is this. In the use of a state-

ment of percentage upon the labeling of the packages of antiseptic dressings, it is generally understood by the dealers and surgeons that the percentage refers to the actual amount by weight of antiseptic in a given weight of the finished product, dry or moist, or does it, or should it, refer to the percentage composition of the solution by which the gauze is medicated in the process of manufacture?

Each proposition has its own advocates, and testimonials and statements of physicians without number may be quoted on either side, in support of either understanding. It is evident, therefore, that a great confusion exists among the users of the gauze, surgeons and physicians, as well as the difference between competing manufacturers. To estimate this difference at its true value, to discover its practical bearing upon the practice of surgery, and to ascertain how it has arisen and why it exists, it is necessary to go back a few years and trace the matter through its various phases and developments down to the present day and to present existing conditions.

Just what formula is most desirable for an antiseptic application, whether a dry or a moist gauze is preferable, is entirely a matter for the surgeon to decide. If he prefer a dry iodoform gauze, containing 10 per cent. by weight of iodoform to 100 parts by weight of the dry, finished gauze, or if he prefer a gauze dipped in a 10 per cent. solution (any chosen formula) and wrung out, but left in a moist condition, this is entirely his affair. He should know, however, but proofs at hand have amply satisfied us that he does not know, in all instances, the exact strength of the medicament applied to the wound. An examination of the formulas of the hospitals and of those in private use by various surgeons, shows in nearly every instance an element of error, whereby any variation in the weight of the gauze, its fineness, etc., may lead to a very decided variation in percentage composition, if the percentage is based upon the weight of the finished product. Does the physician wish to ap-

ply a dry gauze to the wound? If so, he applies the inert substance gauze, bearing pure iodoform. Or does he prefer moist gauze, medicated by a 10 per cent. solution? In this case he is not applying pure iodoform, but a 10 per cent. solution. This is a matter for him to decide, which he prefers.

Let us examine into one or two aspects of the question which appear of importance. The National Formulary, a few other formulas which we have been able to find, and one or two manufacturers base their operations upon percentage of parts by weight in the finished product. A great majority of formulas, however, and more than half of the manufacturers, make a gauze impregnated with a solution of definite percentage strength. Upon comparing the various products some interesting points are brought out. The following are actual weights of the gauzes employed by the firms and institutions mentioned, in grains per square yard:

Lehigh, E. (National Formulary)....	785
Johnson & Johnson.....	585
Bellevue Hospital.....	570
J. Ellwood Lee Co.....	539
Seabury & Johnson.....	436
Hospital Supply Co.....	256

From the above it will be seen how greatly the unmedicated gauze varies in weight per square yard. Now, suppose we use the National Formulary process with these gauzes. To make one square yard of plain gauze 10 per cent. strength, the amounts of iodoform required, in grains per square yard, will be as follows:

Lehigh, E. (National Formulary)....	92
Johnson & Johnson.....	69
Bellevue Hospital.....	67
J. Ellwood Lee Co.....	63
Seabury & Johnson.....	51
Hospital Supply Co.....	30

In other words, one gauze will require in grains more than three times as much as the lightest on the list to make a gauze by the National Formulary process.

Going a step still farther, in order to point out what we consider the fallacy of the finished product standard, attention is called to the following tabular statement which, for the sake of comparison, shows the weights of one yard of iodoform

gauze as finished for the market by the various processes:

Johnson & Johnson.....	1389 gr.
Bellevue Hospital.....	1270 gr.
J. Ellwood Lee Co.....	939 gr.
Lehigh, E. (National Formulary).....	937 gr.
Seabury & Johnson.....	697 gr.
Hospital Supply Co.....	384 gr.

Now, if all these gauzes were required or understood to be of a standard of 10 per cent. by weight of the finished product, the heaviest one would contain five times as much iodoform to the yard as the lightest, or, if the lightest gauze showed 10 per cent. of iodoform by assay, the heaviest gauze would only require from 3 to 4 per cent. to the square yard. In view, therefore, of the confusion and discrepancies and the discussion between surgeons and manufacturers, it appears very evident that the establishment of a definite standard and adherence thereto by the manufacturers is necessary. It is not fair to apply the percentage by weight standard to a moist dressing, for it is easily seen that it may assay less than this standard, and yet really contain two or three or more times as much medicament to the square yard as another dressing, dry, which assays the percentage claimed.

The label on the antiseptic dressing should express its strength, either in grains of the medicament to the square yard, or in percentage of the finished product, or the percentage strength of the solution employed in the medication of the dressing. On this point there should be no agitation whatsoever, and we note that Johnson & Johnson now include upon their labels a statement to the effect that "This gauze is a saturation of sterilized absorbent gauze with a stable emulsion containing 10 per cent. of iodoform. The impregnation is uniformly and accurately adjusted upon a basis of 10 parts of iodoform to 90 parts of dry gauze. Approximately, each square foot contains eight grains of iodoform." Seabury & Johnson state on their labels the percentage by weight of the dry product. If all the manufacturers would follow this course of making the label tell exactly what is contained in the package, there would be no necessity for farther agitation of this percentage matter.

MEDICINE AND CRICKET.

The London Lancet remarks on the benefits of the British national game in its health giving properties and offers congratulations to the champion exponent as follows:

We congratulate Mr. W. G. Grace on the enthusiastic unanimity with which all classes of the community have welcomed the idea of presenting him with a testimonial. We entirely sympathize with a movement having for its object a material proof of the general recognition of the qualities which have raised Mr. Grace to his position of champion exponent of the national game and—by far the more wonderful thing to tell—have maintained him in that position for 20 years. Skill, endurance, patience, courage, strength, delicacy of movement and alertness constitute in different proportions the endowments of the successful cricketer, and the pre-eminent champion at the game may therefore be credited with having displayed for years a just combination of them all. What better man can the sport-loving Briton find to honor than the author of such a display? Mr. Grace's connection with our profession naturally turns our thoughts, subdued to what they work in, in one direction: Has his profession assisted in this maintenance of a remarkably high level of athletic prowess. And we make bold to say, yes. We are not claiming that because the well-trained eye, the skillful hand, and the temperate mood equally comprise the chiefest virtues of the surgeon and the cricketer, a medical education should turn out experts at Lord's. Such a claim, by working both ways, would land us logically in the recommendation to our readers of Gunn for an enterostomy or the younger Druce for a litholapaxy! But we do claim that Mr. Grace's profession has counted for much in keeping him through two decades in the absolute front of the cricketing world. It has given him a wise insight into the rules of health, and furnished him with a knowledge of reasons that cannot have failed to be useful to him in times of physical or mental depression on the field, in unfortu-

nate conjunctions of the game, even in seasons of comparative ill-success. And, considering that his display of evergreen vigor reflects honor upon the principles of medicine, we recommend to the favorable consideration of our readers the project of a national testimonial to our professional brother.

SCHOOL BOY'S MEALS.

At the last meeting of the Association of Medical Officers of Schools, Dr. Horace Savory, medical officer to Haileybury College, read a paper on "Meals of Food for the Schoolboy." The first question that arose, he said, was, How many meals are necessary or advisable, and when should they be taken? He thought there was a general agreement that the main meal should be at midday, from 1 to 1.30, and not in the evening. But did not this cause interference both with work and play? What time ought to elapse before either was undertaken? Was an hour sufficient? Masters often complained that the work done after dinner was not of much use; but he had never known any harm ensue to a boy from playing football an hour after dinner, though it was true that some boys, when they were going to play, ate sparingly at dinner for fear of spoiling their wind. It was unfortunate that we could not give the schoolboy a half-holiday every day to digest his dinner. When lessons had to be done before breakfast, it was most essential that some food should be given before the lessons were commenced. It was a meal that was unpopular both with masters and boys, and at his own school not more than 25 per cent. of the boys took it; but in his opinion it ought to be made compulsory, and not left as at present as a voluntary meal. For children under 12 no work should be allowed before breakfast, and it was quite an open question whether it would not be better to commence the day with the main breakfast, say at 7 or 7.30 A. M.; boys should not be allowed to miss this meal, and there should be responsible people to see that each boy ate it, and an interval

of at least half an hour after it should be allowed. The evening meal should be a substantial tea not later than 7.30; anything like a "sit down" supper was to be avoided, as also any articles of diet likely to cause a disturbed digestion or a loaded bladder in the early hours of the morning. As a rule there should be no feeding at other times, but if a boy was for any reason unable to take his tea he might have some bread and butter and cocoa or milk at night, and of course allowance might always be made by the medical officer for delicate children. The early meal should consist of cocoa, with plenty of milk and bread and butter. Breakfast proper was the meal which most needed improvement; fish, eggs, ham or bacon were most appetizing, and much preferable to cold meat; porridge was an excellent thing, and might be given three or four times a week with plenty of milk and sugar, but it should be given at the end of the meal and not at the beginning, as it was bulky in comparison with its nutritive value and might interfere with a substantial meal being made if taken first. Dinner was of much the same type at all schools; a great difficulty was the supply of green vegetables all the year round and then getting the boys to eat them when they had been provided. At his own school recently soup had been started with satisfactory results, and the cost, with good management, was practically nil. Puddings were always a difficulty, the number of interesting inexpensive varieties being limited, and sometimes the most wholesome was unpopular. He would allow a glass of mild beer, though he did not consider it of any value in the dietary of the healthy schoolboy; he found that about one boy in four drank two glasses of it in summer; it would be unwise to forbid alcohol, as a boy always craved for that which is forbidden. Tea should be mainly farinaceous, tea, bread and butter, and jam being the chief ingredients; meat, cheese, or beer were most inexpedient. He found that a liberal allowance of sugar was very beneficial, and it was also a good plan to

have as great a variety in the bread as possible, and not only in the kind, but a variety in the shape would also tempt boys to eat, and he did not object to the occasional supply of new bread if the loaves were made small so that there should be a large proportion of crust. Dr. Savory then went into the scientific aspects of the question in some detail, inquiring what amount of mechanical work represented in foot pounds would be done by the average schoolboy at different ages, and, further, whether the diet ordained was capable of supplying the necessary potential energy, this part of his paper being illustrated with tables compiled from various sources. The paper concluded with some practical suggestions as to the causes of healthy appetite or the want of it in schoolboys. In the discussion which followed, in which several members took part, a feeling, though not unanimous, was expressed that the evening meal might be made more substantial.

Medicine.

IN CHARGE OF

DR. E. W. BING, Chester, Pa.

DIAGNOSIS OF AFFECTIONS OF THE STOMACH.

Since not every person can make an analysis of the gastric juice for diagnostic purposes it is useful to know some minor means by which a distinction may be made. These are based on the sensations of the patient after a light meal (dejeuner).

When the stomach acts normally no unusual sensations are noted; other symptoms corresponding to the various affections are complained of.

When in about two hours after the meal there is heat in the stomach, a sensation of increased acidity, we have a case of hyperacid dyspepsia. When, on the contrary, flatulence occurs, with heaviness and slowness of digestion, we have hyperacidity. When at the end of about a quarter hour there is uneasiness increasing as in proportion to time, we have irritation of the stomach, or gastro-

duodenitis. In hyperacidity the complaint is not felt till three or four hours after the meal, and is worse at night, especially between the hours of 11 and 1.

At other times the introduction of food either gives ease or provokes pain. In the first case it often means hyperacid dyspepsia, but in painful dyspepsia and gastralgia in chlorotics, there are attacks of pain following the introduction of food. The occupation of the patient often gives useful hints. Hyper acidity and gastric catarrh are frequently seen in persons using alcohol as a beverage.

Decubitus is somewhat useful as a treatment. Where there is stasis of the food or a tendency to it the person should be on the right side, as this favors passage of food out of the stomach.—Rev. Medical.

THE TREATMENT OF LIGHTNING PAINS IN LOCOMOTOR ATAXY.

Blondel (Rev. de Ther., April, 1895) treated a case of locomotor ataxy in a man with syphilitic history, aged 29, who suffered intolerable lightning pains as follows: The patient lay on a bed with the thighs flexed on the abdomen, so that the knees approached the chin, the legs being flexed as much as possible at the same time. A cord passed round the neck and under the knees enabled him to maintain this position for five minutes. This was repeated every night for eight days, when the pains disappeared. As they returned a month after, the same treatment was resumed for five nights. Two years have passed since then, and the man is apparently completely cured. Blondel considers this a scientific method of treatment, causing a slight elongation of the spinal cord in the same way as suspension, without any of the danger which accompanies the latter method, and without any apparatus.

THE REALITY OF APPARENT DEATH.

From time to time the public mind is aroused, or rather, perhaps, we

should say attempts are made to arouse the public mind, by the assertion that cases of premature interment are by no means infrequent. Our attention has been called to a letter in an evening contemporary in which the writer, who, by the way, does not give his name or address, states that a case of supposed premature burial having occurred in his own family has given him a painful interest in the subject, and he is of opinion that such cases are of far more frequent occurrence than is generally admitted. We confess we do not quite know what is meant by this last sentence; we entirely agree with the late Dr. Tidy, when he said: "Whatever may have happened, modern stories of premature burial in England belong to the domain of the novelist rather than of the scientist." The writer of the letter above alluded to says that medical journals rarely take cognizance of reported cases, with a view probably of maintaining the infallibility of medical death certificates, and preserving professional reputations. In this view we can assure him he is absolutely mistaken, and if we do not often take notice of these alleged occurrences it is either because the circumstances under which the story is told are not such as to entitle it to belief, or because no particulars are given enabling us to inquire into the facts for ourselves. We are, however, always open to conviction, and if the correspondent will furnish us with the name of the doctor who certified the death that he mentions as having occurred in his own family, we will do our best to ascertain the truth, for if these cases of premature interment really do occur even occasionally in this country, then the sooner we revise our beliefs as to the signs of death the better. But until we have had the opportunity of investigating one of these cases we shall continue to maintain our attitude of disbelief. The writer incidentally mentions that decomposition is the only reliable sign of death, but if coldness and rigor mortis do not satisfy him, we are surprised that he should accept anything short of actual disintegration of the body as

convincing proof of death. Of course the one crucial early sign of death is the entire and continuous cessation of the heart's action; all other signs are of quite minor importance in comparison with this, for no matter what they may tell us, so long as any trace of movement of the heart can be made out the subject is still living; and, on the other hand, in the words of the leading authority on forensic medicine, it is impossible to admit that the heart can remain for even half an hour in a state of absolute inaction in a human being, and then spontaneously recover its activity.—British Medical Journal.

NUTRITION IN PHTHISIS.

Robin (Arch. gen. de Med., April, 1895) gives the results of his researches into the urinary solids in phthisis. In 43 cases the average daily excretion was about 50 g. in 21 cases, which were either improving or stationary, 33 g. in six cases which were losing ground, and 29 g. in 16 fatal cases. Any case of phthisis in which the average reaches 30 g. may be looked upon, with certain exceptions, as having arrived at the cachetic stage so far as nutrition is concerned. Cases improving under treatment excrete more solids in the urine the weight being stationary, or less solids with increase in weight if fever, diarrhea, or appreciable night sweats are absent. Hemotysis causes a diminution in the urinary solids, persisting for several days. In cases which become worse, a steady diminution in the solids without any increase in weight stands in relation with an aggravation of the malady. In advanced phthisis fever is rarely accompanied by increase in the urinary solids. The supervention of generalized tuberculosis, pneumonia, etc., causes a diminution, and such a sudden diminution should draw attention to the appearance of these complications. In cases treated with increasing doses of cod-liver oil after Jaccoud's method, diminished solids indicate saturation of the body with the oil, which should then be stopped. If the solids then in-

crease without loss of weight it is a favorable sign. As regards the inorganic compounds an increase is noted in early phthisis, and the author thinks that this increase may have something to do with the preparation of the soil for the tubercle bacillus, and may furnish indications for treatment.

Surgery.

IN CHARGE OF

DR. T. H. MANLEY, New York.

AN ABSTRACT ON ESSAY— THE ELEMENT OF THE CIRCULATION IN FRACTURES.

BY THOMAS H. MANLEY, M. D.,

New York.

(Conclusions.)

First. In fractures of every description which involve the shafts of the long bones or the joints of the extremities our first and most important concern is the preservation of the circulation.

Secondly. In compound fractures, associated with an extensive laceration of the blood-trunks, after the parts have been rendered aseptic in the primary dressing for local hemostasis, moderate tamponade with gauze, with prudent bandage pressure, will generally suffice.

But when the larger arteries are lacerated, and it is important to immediately reduce the on-flow through the main arterial trunk, the tourniquet properly adjusted is to be rather relied on.

The Eschmarch bandage, because of the pain attendant on its use, and its great constricting power, should not be indiscriminately employed, nor under any circumstances over a period of more than two hours. Its use is attended with greater danger than any other hemostatic agent in severe lesions of the arteries, associated with a shattering of bone and laceration of the soft parts.

Thirdly. As the main arterial

trunks may sustain varying degrees of damage in so-called simple fracture, thereby threatening the vitality of the parts beyond, in all these cases our attention should first be directed to placing the limb in such a position and under such conditions as will best favor a full re-establishment of the circulation and the preservation of the limb's vitality, irrespective of what the precise state of the disorganized bone may be.

Fourthly. As the vitality of a limb after a serious fracture, with a thrombosed state of an arterial trunk, depends on the prompt establishment of a collateral and peripheral circulation, restraining splints and bandages must not be applied until we are assured that the temporary asphyxia or suspended state of animation in the limb has passed off, and the normal heat has returned; in the meantime, depending on posture, muscular relaxation and the application of artificial heat, to aid in reanimation.

Fifthly. As dry gangrene is the type of molecular death, which follows in the wake of aseptic thromboses of the chief arterial feeders, with proper precautions to preserve the surface aseptic, the parts desiccate up to the line of demarkation, putrescent mortification is wanting, and hence there is no haste to amputate till the processes of nature have clearly defined the limitations of decomposition, and the areas of living parts. A primary amputation here, then, should never be permitted in civil life.

Sixthly. As there are good reasons to believe that the union of fractured bones is sometimes delayed, or even wholly arrested by the premature or too rigid adjustment of them in fixation apparatuses, or, in consequence of them being too long employed, caution should be observed not to unduly constrict the circulation by any sort of mechanical appliance, rather, on the contrary, it is probable that in not an inconsiderable number of fracture cases the circulation of the limb is favored, the nutrition improved, reparative osteogenesis hastened and perfected by occasional moderate motion, mas-

sage and only such an adjustment as will provide support alone to the limb without simultaneously exerting too much pressure.

TRENDELENBURG'S OPERATION FOR VARIX OF THE LEG.

This operation is based on the fact, established chiefly by Trendelenburg's investigations, that the primary cause of the varix is insufficiency of the valves of the veins, whereby the weight of the blood column in the saphena is thrown on the peripheral vessels. It consists in ligation of the saphena in the upper part of the thigh. G. Perthes (*Deut. med. Woch.*, No. 16, 1895) reports 41 cases thus treated, of which 32 were permanently cured. Relapse having been traced in several cases to renewed permeability of the ligatured vein, the rule is now, instead of simply tying the saphena, to exercise a short portion. The results are stated to be surprisingly good, and the proceeding has over Madelung's extirpation of the varices the advantage of simplicity and ease of performance.

A NEW METHOD OF ABDOMINAL HYSTERECTOMY.

At the recent meeting of the American Medical Association (*Med. News*, May 11) N. Senn described the technique of a new method of abdominal hysterectomy. The dangers attending hysterectomy, he said, were shock, hemorrhage, injury to important adjacent organs, and septic infection. The operation now described was intended to remove these dangers. Unnecessary handling of organs and loss of heat were the most active agents in the production of shock. The aim of the operation was to secure access to the myomatous uterus in as short a time and with as little exposure of the organ as possible. After incision, as in the ordinary manner, with ligation of the ovarian arteries, the uterus was brought to the wound. The peritoneum was then incised across the uterus, and the flap thus matched

to the parietal peritoneum. The opposite side was treated in the same manner. This cuff was readily made by means of dissecting forceps and the hand. As soon as the cuff had been sutured to the lower angle of the wound the remainder of the abdominal incision was closed. The tumor or tumors were then extirpated. This part of the operation could be accomplished within a few minutes, and the remainder proceeded with leisurely. The uterus was next amputated at the desired point. If the cervix was affected the entire uterus could be extirpated in the same manner. The uterine arteries were then ligated by an indirect ligature. The arteries need not be isolated, but could be recognized and tied. Amputation was affected by an oblique incision, so made as to form a cone of the uterus and a corresponding depression in the parts left. There was very little hemorrhage if the arteries were tied on both sides. After removal of the uterus the mucous membrane of the cervical canal is cauterized and the uterus closed by chromicized catgut. Two additional rows of buried sutures were then inserted to close the stump and thus arrest parenchymatous oozing. If hemorrhage occurred at any time the amputated surface remained in ready access for the next 48 hours. Adhesions need no longer be dreaded, because the enucleation was the same whether the uterus was adherent or free. If the operator used the necessary antiseptic precautions the only possible source of infection would be the hand or sponges. The wound, two or three inches long, with the stump of the uterus on the floor, was packed with iodoform gauze. Temporary sutures were inserted. In from 24 to 48 hours later the gauze was removed and the wound closed. At no time was there any tension at the stump. If infection should occur after the operation, it was limited to the wound outside of the peritoneum. The crucial test of an operation was furnished by its results. In 32 or 35 unselected cases treated by this method recovery ensued in all without untoward results.

Gynecology and Obstetrics.

THE THERAPEUTIC ACTION OF CHLOROFORM IN PARTURITION.

At the recent meeting of the American Medical Association Bedford Brown (Med. News, May 18) read a paper on the use of chloroform in labor. He said that in all literature there are reported not more than 40 cases of death from chloroform in labor. He had used the anesthetic, given every half hour for from 20 to 40 hours, without any trouble following. He had seen profound chloroform narcosis in obstetrics lasting for three or four hours without grave effects. He objected, however, to the careless use of the anesthetic. The alteration in the vasomotor system of a pregnant woman enabled her to resist the toxic action of chloroform to this wonderful extent. Was the use of chloroform in labor for the relief of pain alone justifiable? He believed it was not only justifiable, but that it would be inhuman to withhold it. At what stage of parturition was chloroform applicable? For pain in any stage in small quantities. To remove muscular rigidity of the cervix or perineum a larger quantity was required, until there followed complete muscular relaxation. Did chloroform tend to prevent uterine contractions? If given in sufficient quantity it would do this. Did its use tend to promote hemorrhage? He had never seen a greater tendency to hemorrhage after than without its use. In 2000 cases of labor which he had attended he had given chloroform in 1500 without ill effects following.

DANGERS OF THE CURETTE.

During recent years the use of the curette in gynecology has become much more general, and the treatment has proved to be not only scientific, but successful in cases, for example, of small growths in the uterine canal, or of the fungous condition of the endometrium, which for-

merly proved so rebellious to treatment. The removal of these conditions by scraping them away has become a comparatively easy matter. This very success, however, has led, perhaps, to the curette being used, in some cases, rather recklessly, and it is necessary to emphasize the caution to which a French writer has recently drawn attention, that the use of this instrument may sometimes prove very dangerous. The curette has, for example, been known to perforate the uterus, and it must be remembered that, especially after pregnancy, or in cases in which growths have persisted for some length of time in the canal, the substance of the uterine wall becomes abnormally soft. Then, again, there are cases known to many gynecologists in which a pelvic abscess existed, and had been overlooked, or in which a pyosalpinx had been unobserved; and in both these conditions the active treatment of the canal of the uterus by the curette has led to rupture of the abscess sac, with rapidly fatal results. It is, therefore, important to remember that, valuable as the curette is, its use is far from being unattended with danger, and that simple as its action appears to be, in the hands of an expert, and under the proper conditions of dilatation of the cervical canal, there are many instances in which carelessly or improperly employed, it has caused irreparable harm, and even rapidly fatal results.—Med. T. and H. G.

TREATMENT OF ABORTION.

Dr. Nicholas Sarmak, of Biele, Polish Russia, in *Therapeutische Mowatshefter*, reports 40 cases of threatening abortion where hemorrhage had set in with contraction of the uterus, treated with injection of 30 drops of *Tr. asafetida* in one or three ounces of water three times daily. In 37 cases the hemorrhage and contractions of the uterus ceased and pregnancy progressed, and only in three cases the treatment was without good results.

Also in habitual abortion he had good results by the exipition of asa-

fetida in the following manner: *Gume resinae asafetida*, gr. 90, made into 60 pills, and give two daily and increase until 10 are taken daily and then decrease. In one case where patient had aborted 14 times under the above treatment patient went to full term.

THE FUTURE TREATMENT OF SEPTIC PELVIC DISEASES.

Heurotin (*Amer. Gynec. and Obstet. Journ.*, May, 1895) thinks that in 10 years these affections will be treated in a more definite manner than at present. Having failed to stop the disease within the uterus physicians will not wait idly by whilst peritonitis and cellulitis play havoc and produce incurable destructive conditions. Incipient phlegm in the broad ligaments will be incised and drained early, intrautubal disease will be recognized in time for conservative treatment, which will follow the perfection of radical work. In neglected cases, when the appendages are the seat of chronic diseases, they will not always be sacrificed; in a young subject drainage of an ovarian or tubal abscess may be followed by cure and restored function. The incision in such a case will be made through the abdominal parietes. But when it is evident that both appendages are hopelessly diseased hysterectomy through the vagina, with complete removal of the appendages, will be practiced. Too many radical operations are now performed; 10 years hence conservative treatment will save numerous ovaries.

Miscellany.

TETANUS TREATED BY ANTI-TOXIN.

Matteucci (*Rif. Med.*, April 22, 1895) reports the case of a man whom he first saw on March 15, complaining of general malaise, rheumatic pains (attributed to a chill), and some stiffness of the jaw. On March

19 there were decided symptoms of tetanus—*risus sardonius*, *opisthotonos*, rigidity of the lower limbs. There was no history of injury and no recent scar. The only supposed cause was a chill three or four days before, when the patient was suffering from aphthous stomatitis. On March 23 the patient was worse, speech was hardly intelligible, the finger could not be introduced into the mouth, and tetanic spasms occurred—about 20 every hour. Tizzoni then saw the patient, and injected 30 c.cm. of antitoxin serum (of 1 to 10 mil. immunizing powder) prepared by him and taken from a horse two days previously. On March 24 the patient was better, the spasms were less intense, less frequent and less painful. The injection was followed by a copious eruption of urticaria, rise of temperature (39 degrees C.), and profuse sweating. Injections of 10 c. cm. were made on the 24th, 25th and 26th, and were also followed by urticaria and raised temperature, but to a less degree. After the injections were begun the patient steadily improved, so that on April 1 the abdominal walls were relaxed. On April 5 mastication was possible, and on April 8 recovery was complete and he was able to leave his bed. Sedative injections of morphine were used as supplementary aids to the antitoxin treatment.

POTASSIUM IODIDE AND IMMUNITY OF CATTLE AGAINST FOOT-AND-MOUTH DISEASE.

Pick (Centralbl. f. Baht., u. Parasitk., March 23, 1895) publishes some facts which appear to show that the administration of potassium iodide to cattle produces immunity against foot and mouth disease. Whilst the author was making experiments on two cows in order to obtain iodized milk for therapeutic use an epidemic of foot-and-mouth disease occurred. One case had been receiving 12 grammes of potassium iodide daily for eight weeks, the other cow the same quantity for 10 weeks, when the disease broke out in the stable in which these cows, along with 68

other cows, were kept. The disease spread rapidly and, as is the custom in such cases, in order to shorten the epidemic all the cattle were subjected to injection by wiping out the mouth cavity of the diseased cows with a cloth, and then bringing it in contact with the mouths of the healthy animals. The result was that all the cattle suffered from the disease except the two cows which had been treated with potassium iodide. Though these were subjected to the same procedure as the rest they remained unaffected by the disease. These two cows were not isolated from the others, and the cows to the right and to the left (in the stable) suffered from the disease. In spite of the usual precautions the cows in the second stable were all affected with the disease. As the predisposition from the disease amongst cattle is very great and general, and as both the iodised cows had certainly not suffered from the disease previously; and further, as neither in the manner of feeding nor in the external conditions was there any difference, the author believes that immunity was due to the use of the potassium iodide.

FOR FLATULENCE.

When flatulence is associated with pain after food and a coated tongue indicating gastritis, the following prescription should be given:

Potassii Bicarb. vel Sodii Bicarb. dr. ij
Sp. Ammon. Arom. dr. jss.
Liq. Strychninae M xxx.
Sp. Armoraciae Co. vel Sp. Cajuputi dr. ij.
Sp. Chloroformi dr. j.
Infus. Calumbae vel Gentianae Co.*
ad oz. vj.

M. ft. mist. A sixth part three times a day between meals.—S. Mackenzie in London Practitioner.

SOME USES OF SALICYLATE OF SODA.

The power of salicylate of soda as a cholagogue is apt to be forgotten. Yet its action as a hepatic stimulant has been studied by Rutherford Blanchier and Lewascheff, and confirmed by experimental research. As an analgesic there are frequently

cases of sciatica, cerebral rheumatism, hemicrania, etc., where the preparations of salicylic acid, and particularly the salicylate of soda, will render real and useful services. In attacks of migraine the latter salt may be thus prescribed:

R—Sodæ Salicylat. grs. xx.
Caffein. Citrat. Effervesc. dr. ij.

Ft. Dosis. To be taken in half a wineglass of water, and repeated every two or three hours until the headache is relieved.

A useful mixture in acute bronchitis contains salicylate of soda, as suggested in the *Semaine Medicale* (Jan. 9, 1895):

R—Sod. Salicylat. dr. j.
Ammom. Carb. dr. j.
Tinct. Camph. Co. dr. j.
Syrup. Aurantii oz. ss.
Syrup. Tolut. oz. ss.
Aq. ad oz. iv.

Ft. Mist. S. A dessertspoonful every three hours.

As a deodoriser in cancer of the uterus:

R—Acid. Salicylic. grs. vj.
Sod. Salicylat. dr. iij.
Tinct. Eucalypt. dr. vj.
Aq. Destill. ad oz. vj.

S. Two or three tablespoonfuls to a pint of water as an injection.—
London Practitioner.

THE NEW YORK CITY BOARD OF HEALTH.

Dr. Cyrus Edson's resignation from the board seems to have been demanded of him in a manner that left him no alternative to the course he has taken, that of sending it in in a form to take effect at once rather than at the Mayor's pleasure. The appointment of Dr. George B. Fowler to succeed him was not, so far as we are aware, among the things that were generally expected, but this at least may be said of it, that it is reasonably sure not to lead to acerbity in the board's proceedings. It is to be hoped that the board is not to lose the services of its president, Mr. Wilson, who is undoubtedly better fitted for the office than any other eligible man who could be found to fill it—to be eligible, one must not be a member of the medical profession!—*N. Y. Med. Jour.*

SCIENTIFIC HOUSEWIFE.

Give me a spoon of oleo, ma,
And the sodium alkali,
For I'm going to make a pie, mamma,
I'm going to make a pie;
For John will be hungry and tired, ma,
And his tissues will decompose—
So give me a gramme of phosphate,
And the carbon and cellulose.

Now, give me a chunk of casein, ma,
To shorten the thermic fat;
And hand me the oxygen bottle, ma,
And look at the thermostat;
And if the electric oven's cold,
Just turn it on half an ohm,
For I want to have supper ready,
As soon as John comes home.

Now, pass me the neutral dope, mamma,
And rotate the mixing machine,
But give me the sterilized water first
And the oleomargarine,
And the phosphate too, for, now I think,
The new typewriter's quit,
And John will need more phosphate food
To help his brain a bit.

—Chicago News.

The *Index Medicus*, of Washington, has suspended publication.

Correspondence.

Editor "Times and Register:"—
From many sources I have received circulars which had been distributed by the Oakland Chemical Company and the senders, according to the accompanying letters, appear to be impressed that the Oakland Chemical Company in these circulars seem to depreciate the value of my analyses. I take the liberty to inform you that my report on the real value of the different brands of peroxide of hydrogen, which was published by the "Times and Register," December 15, 1894, is correct from beginning to end. I will further say that the analyses of the O. C. Peroxide of hydrogen medicinal, published by the same paper June 1, 1895, are also correct.

It merely shows that the first samples bought and tested by me in November, 1894, contained soluble barium salts, and that the samples bought and tested in May, 1895, did not contain them.

Very respectfully,
H. ENDEMANN.

New York, July 1, 1895.